IN THE UNITED STATES DISTRICT COURT FOR
THE MIDDLE DISTRICT OF NORTH CAROLINA

MAXWELL KADEL, et al.,
Plaintiffs,
V.
DALE FOLWELL, et al.,
Defendants.

No. 1:19-cv-272-LCB-LPA

DEPOSITION
OF
DEE JONES

IN HER INDIVIDUAL CAPACITY
and
30(b)(6) DESIGNEE FOR NC STATE HEALTH PLAN

AUGUST 3, 2021

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PNC PLAZA DOWNTOWN
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Reported by: Michelle Maar, RDR, RMR, FCRR

Q. And in 2016, did the Plan's benefits coverage provide for blanket exclusions for treatment of gender dysphoria?

A. Yes.

Q. I would like to show you what I'm marking as Plaintiffs' Exhibit 1.

(Exhibit 1 is marked for identification.)

MS. RAVI: I'll give you a moment to review the document. I know it's lengthy.

MR. RULEY: You've seen it before.

THE WITNESS: I've seen it once or twice.

BY MS. RAVI:

Q. Do you recognize this document?

A. I do.

Q. What is this?

A. It is the 80/20 PPO Plan Benefits Booklet for the period January 1 through December 31 of 2016.

Q. Would you turn to the page marked as PLAN DEF2711.

In the 2016 Plan Year, did the Plan exclude from coverage treatment or studies leading to or in connection with sex changes or modifications and related care?

A. Yes.

Q. If you could turn to the page marked PLAN DEF2699.

In the 2016 Plan Year, did the Plan exclude from coverage psychological assessment and psychotherapy treatment in conjunction with proposed gender transformation?

A. Yes.

Q. If I refer to these two exclusions from coverage today as the exclusions, will you know what I'm talking about?

A. Yes.

Q. All right. When was this exclusion language added to the Plan documents?

A. As I understand it, back into the '90s in some capacity.

Q. And with the exception of Plan Year 2017, has the exclusion been in place continuously since it was introduced?

A. As I understand it, yes.

Q. And is that correct for the 80/20 PPO Plan?

A. Yes.

Q. Is that also correct for the 70/30 PPO Plan?

A. Yes.

Q. And for the High-Deductible Health Plan?

A. Yes.

Q. Who is eligible to enroll in the State Health Plan?

A. State employees, teachers, public school teachers, employees of the University Systems of North Carolina, employees of the Community College System, lawmakers, and former lawmakers, some charter schools, some municipalities, and, of course, state agencies.

Q. Okay. And by that, you mean employees of charter schools, municipalities, and state agencies?

A. Yes.

Q. Anyone else?

A. No.

Q. And what is the plan year?

A. January 1 through December 31st.

Q. All right. Can you generally describe the process by which the Plan determines benefits for a subsequent plan year?

A. We start with the existing benefits. And unless there are any material, or changes that the Plan has decided to add, it will be the same booklet or same benefits going forward.

Q. How does the Plan decide whether to make changes going forward?

A. Starting with the overarching goal of providing healthcare for its members, and recognizing that we are a government plan, and recognizing that we have limited funding all provided by taxpayers, we start with that.

Q. Did you discuss this recommendation with the State Treasurer?

A. No.

Q. Is it correct that care must be medically necessary to be covered by your Plan?

A. Yes. But the Plan does not cover all medically necessary treatment.

Q. At the time of this draft resolution, was it the Plan's position that gender transition services were medically necessary care?

MR. RULEY: Objection, form.

THE WITNESS: Again, a lot of things are medically necessary that the Plan doesn't cover. And a lot is not, it's maybe a little bit of a loaded word. But that is what it says here.

BY MS. RAVI:

Q. I'm sorry -- could you clarify when you say that is what it says here?

A. It says here in the resolution that the board approve medically necessary coverage.

Q. Medically necessary coverage of gender transition services?

A. Yes.

Q. Regarding the position on whether or not gender transition services are medically necessary coverage, has

A. That is correct.

Q. What was the basis for that reference?

A. This is the Treasurer's words. I'm not aware of what he was referring to. I don't disagree with it. But these are his words.

Q. All right. Are you aware of the Treasurer's basis for this statement?

A. No.

Q. Does the Plan believe the treatment for gender dysphoria is medically uncertain?

A. Yes.

Q. When did this view develop?

A. Please repeat.

Q. When did this view develop?

A. I would say over several years. In 2016, it's very clear that while the presentations had a lot of supporting documentation, the basis of the sunsetting or the removal of the exclusion was based on the 1557 Rule and the need to keep the federal funding.

And the Plan at the time, the staff used and put forth all sorts of other information when we just went through.

But since that time, we have new staff, we have a small staff, we manage contracts, and we have limited clinical staff.

But the people we work with, and as I already mentioned the journals or whatever that I have reviewed and discussions we've had with current and former board members, there's a lot of uncertainty on whether or not the treatments are effective. And in some cases, maybe they are. But there's discussion in the space of the, more the psychological effects and how much it's important there versus the surgery, the transition surgery.

Q. And what was the basis for Treasurer Folwell's statement regarding the medical uncertainty?

MR. RULEY: Objection, form.

THE WITNESS: I don't know.

BY MS. RAVI:

Q. Did Treasurer Folwell discuss this statement with you?

A. No.

Q. Did Treasurer Folwell discuss this statement with anyone at the Plan?

A. I'm not aware of any conversations he had with anybody at the Plan.

Q. And does this statement from October 25th reflect the views of the State Health Plan?

A. Parts of it might, such as the legal and medical uncertainty.

The Franciscan Alliance opinion came out in

December of 2016. And we know there were various cases in Texas I believe.

So, again, I think there's legal uncertainty. I think there's medical uncertainty. And our thoughts kind of went down that direction.

Plus the fact that this is such, as we already went through, the Blue Cross spreadsheet that was part of the record, where it's such a small part of the Plan membership that this benefit would apply to. It's a niche. I call that a niche, a small population of people.

And the Plan can't cover every requested benefit for every single niche that comes forward, niche population. It happens all the time.

You know, I have to turn down parents who want a special feeding benefit for their infant children who can't process food normally.

I have to turn down hearing aids for a much larger population of people because they're so expensive. There's plenty of efficacy there, right? It helps people hear. But the fact that they have to change hearing aids every five to six years or more frequently, I can't afford that as a Plan.

Because if I -- I have to serve a whole entire population with a very finite amount of money. And so the only thing I can really cover is the current state of

benefits and any benefits that might apply to a broad swath of the population with a not guaranteed but a strong proponent of lower costs in the future.

And so that's where legal and medical uncertainty -- I don't have to cover medically necessary treatment. We cover a lot of it. But in this case, we don't.

Q. Prior to this statement coming out on October 25, 2018, did Plan staff discuss the legal uncertainty that's referenced here?

A. Yes.

Q. Did Plan staff discuss the medical uncertainty that's referenced here?

A. Yes.

Q. Let's turn back to Exhibit 5. And if you can turn to Page 10 of this document.

Plaintiffs' Interrogatory Number 3 asks the Plan to discuss the factual basis for each governmental interest that the Plan contends supports the exclusion.

Is that right?

A. Yes.

Q. And is it correct, turning to the next page, the Plan states that the Plan has not identified any valid, reliable, peer-reviewed longitudinal studies that support the efficacy of the plaintiffs' desired treatment?

A. I'm sorry -- where are you?

Q. I am at the bottom of Page 11, last paragraph.

A. Okay.

That would be true.

Q. Is a peer-reviewed, longitudinal study that supports the efficacy of treatment a prerequisite for the Plan to cover a proposed benefit?

A. Not necessarily. When we evaluate, as I think we said earlier, it's a holistic review. There's no single pathway to coverage. It has to be a broad swath of membership, that there's a benefit for multiple people.

There's a cost component to it. There's a downstream cost component to it. There's got to be some common -- not experimental for sure.

There's got to be some common understanding in the medical community that it is a treatment that will produce a downstream effect that's positive.

So, you know, it's very difficult to come back and say well, peer-reviewed, longitudinal studies -- I'm not a clinician and I'm not a researcher, so it's, you know -- but to the extent that we have not found any real evidence that it's absolutely black and white, this particular issue.

You know, I think it goes, well, it should go without saying this is not a personal issue for me. I don't get, I have no personal opinion about this.

Because I walk through the front door at the office, and I'm a fiduciary. This is all about the cost and maintaining this benefit for 740,000 people who expect it every single day and the retirees that have an expectation of the benefit when they retire.

And so every decision I make -- and I'm speaking for myself -- is about that. It's all about that every day.

It breaks my heart 9 times out of 10 when I have to decline a benefit, 9 times out of 10.

When I see people that need hearing aids, I would love to give them a hearing aid, I would love to.

I have nothing against transgender people. I would be more than happy to provide the benefit. But it's not my decision. I'm a fiduciary first. And I'm responsible for 740,000 people. This is not personal. This is all about money very simply put.

I've been charged with reducing the costs of the Plan to operate since the day I started. And we have done just that.

You know, there's some discussions about how much money the Plan has saved. Well, it's because we've worked really hard to do that. We've taken out all extraneous benefits.

We used to cover benefits for a small population

A. Yes.

Q. So looking at all enrollees in the Plan, 15 percent of those enrollees account for 85 percent of the cost of treatment?

A. Correct.

Q. Can an individual enrolled in the State Health Plan request that the State Health Plan change the pronoun associated with that enrollee?

A. Please rephrase.

Q. Can an individual that's enrolled in the State Health Plan request that the Plan change in its records the pronoun that's associated with that individual?

A. The member can change his or her own pronoun.

Q. How does that process occur?

A. The member logs in to eBenefits or calls into the call center, benefit-focused call center, and either changes it him or herself, or requests that it be changed.

Q. Okay.

A. It's not validated.

Q. What does that mean for it not to be validated?

A. You could put in whatever you want. There's two options, male or female.

And if I were female and put in female, I could do that. Or if I wanted to put in male, I can do that. If I make an error, I can do that too.

Q. And you said an individual can either log in and change that themselves or they can make a request that the Plan make that change?

A. No. They call into the call center, talk to a call center rep who will record the call. And then they can be requested to make that change.

Q. To whom is that request made?

A. The call center rep.

Q. If a call center rep gets that kind of request, what happens next?

A. They comply with the request.

Q. And how does that process occur?

A. They go into the system and check yes or no or male or female or exactly -- I guess it's male or female.

Q. And prior to going into the system, is any validation requested?

A. Absolutely. Whatever -- like the member would call in, and there would be validation questions from the call center rep back to the member to confirm any number of demographic statistics.

Q. What are those validation questions?

A. I don't know them specifically. But it's something that would be similar to what we all do, which is your address, your full name, possibly your Social Security number, you know, phone numbers, whatever, to try to --

they're a vendor. I don't tell them how to do their job. I just tell them they have to validate it. It's not my obligation how to exactly do it.

Q. So is it fair to say that validation is with respect to making sure that the person calling in and making this request is who they say they are?

A. Yes.

Q. Does the Plan require proof of any enrollee's chromosomes before it goes into the system and complies with that question?

A. No.

Q. Does it require proof of an enrollee's anatomy?

A. No.

Q. And does it require proof of an enrollee's DNA?

A. No.

Q. Everything we just talked about with regard to changing the pronoun in the system, does that also apply to a request to change an individual enrollee's gender marker in the system?

A. We don't track gender markers in the system other than male or female. We only have but two options right now.

Q. Is participation in the Plan required for state agency employees?

A. No. They have a choice. I mean the benefit

role, but I would say we have two people, we have a real actuary, Charles Seifert. And we have a financial analyst, Tamera McNeal.

Q. And you said it's a different perspective with regard to how issues are approached with current Plan staff --

A. Uh-huh.

Q. -- as opposed to Plan staff in 2016.

A. Uh-huh.

Q. Can you clarify that?

A. In 2016, there was Mona and Lotta and Caroline. And they seemed to make all the decisions and were supported by staff and maybe some of the clinical perspective that -- they actually had more clinicians back in those days.

Today, we are a flatter staff. And we have a very diverse group of experience and background and skill sets. And so we bring them all to the table.

And we work through -- again, our focus, at the direction of the Treasurer, is about making sure the Plan is in existence tomorrow, in five years, in ten years.

And that's really hard to do when we're being funded at a 4 percent or better or less level, and our trend rates are at 7 percent. The math just doesn't work.

Q. With regard to the Plan's current staff, is there

not personal. This is not something that I get to make a choice about. Because if I had every single group that comes in to ask for a benefit, if I covered that, then I would be completely, completely avoiding my fiduciary responsibility to cover basic health. That's what the Plan Benefits Booklet says, right?

The Plan Benefits Booklet identifies every single thing I cover. And it provides healthcare. We want every member of the Plan to have good healthcare. We want the -- and the reality is we have a lot of members who have diabetes. We have a lot of members who have orthopedic issues. We have a lot of members who have RA. We have really a lot of members who have cancer. And they want to be, they want to be covered.

And so it's really difficult for me to just say, you know, I can take this group of 25 and this group of 10 and these -- if you add all that up -- I'll, I'll totally admit that the cost of this benefit is not going to break the Plan, never was, never will.

But it -- I can't do it for that group and not do it for the group that wants it for their infants, for, you know, for a certain feeding formula for that infant group, and I can't do it for the hearing aid group, and I can't do it for the group that really wants acupuncture.

Because once you start adding those, then I have

to keep going. Everybody who comes in and wants a benefit, I'll have to do it because I can't discriminate.

I'm not discriminating. This is about what the Plan can afford in the environment that we're in today -- which is I have a General Assembly that's funding me at 4 percent when my trend rate is 7 plus. And that's not even absolutely certain.

I have a 28.8 billion unfunded liability for retiree healthcare that I, myself, am ready to have in a few years.

And so, you know, this is all about being a government plan. And I don't get to, I don't get to pick and choose. I'm not a commercial plan.

So let's start with that. A commercial plan, they have revenues, right? You go out and sell widgets, and you sell a lot of widgets, and then you decide how much you want to put into the benefit. And you can have your member, your staff, your employees pay.

I would bet most employers -- I was paying 100 bucks when I was at Time Warner. I was paying for the family, and I wasn't fully subsidized.

At the State Health Plan, we've got people who, a whole lot of employees have to work one week out of a month just to cover their Health Plan for their family.

And the effort to just institute a 25 dollar

premium for the 70/30 Plan and a 50 dollar premium for the 80/20 Plan was a herculean effort. They had never paid anything until 2018. Employees had never paid anything until 2018 -- which is crazy. I mean I get that.

But we can't just keep adding costs to the Plan.

And the General Assembly, in the 2016 budget, I think it's 2016-94, something like that, said you got to stop, you've got to control your costs, you're not getting more than 4 percent, and you can't go over.

So what happens when I spend more than I've got? I've got to charge employees. And I got to charge employees who, you know, read the, you know employees don't make market rates. They just don't.

And so it is a very tight -- I mean I live in a box. And there's not a lot of room in the box to move because I have the General Assembly describing what I can do. You know, it's all -- eligibility, it's all in statute. My funding is all in statute, in the budget bill. And that's one box.

I work with vendors who I have to make them work together. And, quite frankly, as big as we are, I got at least one vendor that's not real cooperative. And it's really annoying. But it doesn't matter -- apparently, to some vendors, it doesn't matter that we're the biggest Health Plan, you know, one of the biggest in the nation.

-- if that's okay.

MS. RAVI: Alan, I think we're taking another 5 to 10 minute break, and then we'll be back.

(Off the record)

MR. RULEY: I have just a few follow-up questions for you.

EXAMINATION

BY MR. RULEY:

Q. Would you find Exhibit 1 please. Would you turn to Page 50 please.

Page 50 is titled What Is Not Covered? Is that right?

A. That is correct.

Q. And are these basically exclusions, a list of exclusions?

A. Yes.

Q. And would you look at the fourth bullet point.

A. Yes.

Q. What is that exclusion?

A. Any experimental drug or any drug or device not approved by the Food and Drug Administration (FDA) for the applicable diagnosis or treatment.

Q. Then turning the page to Page 51, the fourth bullet point from the bottom, what is that exclusion?

A. Surgical procedures for psychological or emotional reasons.

Q. And would those exclusions also potentially apply to coverage for gender dysphoria?

A. Yes.

Q. Earlier, you mentioned HBRs. What are they again please?

A. Health Benefit Representatives. They are actually defined in statute. And they work at the various employing units. I mentioned there are 408. They are liaisons to the Plan. So the Plan teaches them, keeps them apprised of the benefits being offered. But they're responsible for their employer's employees and getting them enrolled and making sure they understand the processes.

Q. So are they employed by the State Health Plan or by others?

A. By the others.

Q. All right. Thank you.

On costs -- would you get Exhibits 6 and 7 please.

Looking at Exhibit 6, for example, look at the first e-mail on Exhibit 6, Page DEF61647, the January 22, 2017 e-mail.

A. Yes.

Q. And that reports, as of 1-21, a total paid of 287.57.